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Variation in referral and access to new psychological therapy services by age

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Abstract

Background: Older people with common mental health problems (CMHPs) are known to have reduced rates of referral to psychological therapy.

Aim: We aimed to assess referral rates to the Improving Access to Psychological Therapies (IAPT) service, contact with a therapist and clinical outcome by age.

Design and Setting: Empirical research using patient episodes of care from South West IAPT.

Method: By analysing 82,513 episodes of care (2010-2011), referral rates and clinical improvement were compared to both total population and estimated prevalence in each age group using IAPT data. Probable recovery of those completing treatment were calculated for each group.

Results: Estimated prevalence of CMHPs peaks in 45–49 year olds (20.59% of population). The proportions of patients identified with CMHPs being referred peaks at 20-24 years (22.95%) and reduces with increase in age thereafter to 6.00% for 70-74 year olds. Once referred, the proportion of those attending first treatment increases with age between 18 years (57.64%) and 64 years (76.97%). In addition, the percentage of those having a clinical improvement gradually increases from the age 20 years (12.94%) to 69 years (20.74%).

Conclusion: Younger adults are more readily referred to IAPT services. However, as a proportion of those referred, probabilities of attending once, attending more than once, and clinical improvement, increase with age. It is uncertain whether optimum levels of referral have been reached for young adults. It is important to establish whether changes to service configuration, treatment options, and GP behaviour can increase referrals for middle-aged and older adults.

Keywords: IAPT, Age Factors; Mental Health; Referral; Psychological Therapy

INTRODUCTION

In 2009, the Royal College of Psychiatrists suggested the UK currently provides more mental health services for those younger than 65 years of age than older people[1]. Barriers to mental health treatment are known to differ by age[2] and concerns that discrimination against older adults may cause reduced access to mental health treatments including talking therapies are expressed[3]. Data available from the Improving Access to Psychological Therapies (IAPT) programme, which aimed to equitably improve access, allows us to explore the degree to which inequalities persist across different age groups.

The Adult Psychiatric Morbidity Survey (APMS) provides data on the prevalence of psychiatric disorder (treated and untreated) in the English adult population. 'Common Mental Health Problems' (CMHPs) is an umbrella term describing difficulties in low mood and anxiety and is a descendent of the term 'common mental disorders'. The APMS describes common mental disorders as conditions comprising of different types of depression and anxiety[4]. Data from the APMS suggest prevalence of depression reduces with age from middle-age onwards[4], a finding supported by others[5] but not by Stordal and colleagues[6] who reported a linear increase of depression with increasing age after carefully adjusting for confounders for individuals in Norway. Whatever the truth about prevalence, inequity of access appears clear. In the 1990's fewer than 3% of adults aged over 65 years reported seeing a mental health professional[7]. Using data from the APMS (2007), Cooper and colleagues[8] found younger adults (16-34 years) to be 80% more likely than older adults (75+ years) with the same severity of common mental health problems (CMHPs) to be receiving talking therapy. In contrast, older adults were more likely than younger adults to receive anti-depressants or anxiolytics and hypnotics, suggesting older adults are being prescribed medication rather than talking therapy and vice versa.

Inequities in access to talking therapies across age may be dependent on patient attitudes, practitioner attitudes and/or system factors. Depressive symptoms are common in older adults, but psychological adjustment to aging and chronic illness may mean symptoms are not acknowledged or revealed[9]. It may be assumed by some health care professionals that older adults experience psychological distress as a natural and inevitable consequence of aging[9, 10]. Ross and Hardy[11]

found GP decisions were influenced by patients' help-seeking behaviours as well as their representations of mental health problems. GPs may believe older adults are less responsive to cognitive behavioural therapy than younger adults[12, 13]. Patients believing they can 'manage themselves' increases with age, making it less likely they will disclose their mental health problems to a GP, less likely they will be referred, and less likely they will accept offered treatment[14, 15]. It is possible that older adults attribute their symptoms to physical complaints, whereas younger adults have greater awareness of psychological problems[10]. Older adult's inability to express their psychological problems, and greater self-stigma reduces the likelihood they are to seek help[10], or be offered appropriate help by health care professionals[11], creating further inequities in access to mental health treatment dependant on age.

In 2008, the development of new psychological therapy services across England under the IAPT programme, improved access to treatments for CMHPs[2] which included individuals with obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) as well as the more prevalent anxiety and depression. By 2011, 142 Primary Care Trusts (PCTs) had an IAPT service and £400 million was being invested up to 2015. Targets for rates of access to psychological therapy included services providing enough therapists to meet the needs of the whole PCT population, with half of those who complete the programme moving to recovery[16]. IAPT services include routine collection of session by session outcome data for all individuals referred. The IAPT data allows exploration of differences in access to mental health treatments across age, allowing comparisons of referrals, access to the services and responses to treatment.

Previous audits and monitoring suggest access to talking therapies is greater for younger individuals[8]. This paper aimed to accurately estimate differences in referral and access rates to the IAPT service and to compare pathway through treatment across age bands, controlling for predicted prevalence of CMHPs.

METHOD

Our overall design was to derive figures in each age band for total population, estimated prevalence and numbers referred, seen, and patients who achieved the minimal clinical important difference (MCID) in symptoms; and then to calculate rates using different key denominators. The most recent APMS (survey three, 2007) data were analysed with data collected from IAPT services in thirteen Primary Care Trusts (PCTs) from 2010-2011. The dataset was created for a

service evaluation project of the IAPT services commissioned by the South West Strategic Health Authority.

Population and prevalence data were obtained from the APMS survey which used a robust stratified, multi-stage probability sample of households which assessed and diagnosed psychiatric disorder according to diagnostic criteria where possible. Participants completed the revised Clinical Interview Schedule (CIS-R)[17] which measures symptoms linked to the diagnosis of anxiety and depression, and provides an overall score for the presence of CMHPs (indicated by a score of 12 or above). The APMS series is the largest, most detailed, and most recent (2007) data available for comparison of IAPT service use. The APMS provided numbers on estimated prevalence of CMHPs across gender (which we combined), as well as total population, in each of the thirteen PCTs individually. Using this data, the numbers of people in each age group in the South West and the numbers of people in each age group in the South West who were estimated to have CMHPs were totalled, and these were used as denominators to calculate rates and proportions.

Numbers of people referred, obtaining access and the associated clinical outcomes were derived from the South West IAPT evaluation database which includes information from the IAPT service providers' databases relating to 13 South West PCTs. We included individuals aged between 18 and 74 years of age in the study to reflect data taken from the APMS (which excludes those in care homes). The anonymised referral, access and outcome data were generated from 82,513 individual episodes of care (76,734 patients). Patients' demographic information (including age) and details of attendance, and health outcomes were recorded at every clinical contact. The latter included the Patient Health Questionnaire (PHQ-9)[18] as a measure of depression, and the Generalised Anxiety Disorder (GAD-7)[19] questionnaire as a measure of anxiety.

We estimated the proportions of the total populations having CMHPs; being referred to IAPT; obtaining access by attending their first session with an IAPT therapist; treatment engagement by attending at least one further session; and those achieving MCID in both the PHQ-9 and the GAD-7. We calculated the proportions of those estimated to have CMHPs being referred to IAPT; obtaining access by attending their first session with an IAPT therapist; treatment engagement by attending at least one further session; and those achieving MCID. We then calculated the proportions of referred patients obtaining access; treatment engagement by

attending at least one further session; and those achieving MCID. MCID was also shown as a proportion of those with two or more treatment sessions.

To calculate the MCID patients must have attended two or more (valid) clinical contacts and improvement was measured by comparing final therapy session score with baseline session score on the following outcome measures. The MCID value for PHQ-9 is a reduction of 5 or more points between first and last session and for GAD-7 it is a reduction of 4 or more points between first and last session[20]. The proportion achieving the MCID in both PHQ-9 and GAD-7 by those with more than two therapy sessions in each age group was then calculated.

RESULTS

There were 82,513 treatment episodes recorded across the 13 IAPT services in the South West of England. The number of people in each age group in the study area is shown in table one along with the estimated number of people with CMHPs and the numbers of people referred to IAPT services, attending at least one session with an IAPT practitioner, uptake of treatment by at least one further session and achieving MCID. The numbers are also expressed as proportions of estimated prevalence, of referrals and of those seen.

Estimated prevalence of CMHPs peaks in 45-49 year olds (20.59%), with lowest estimated prevalence in 70-74 year olds (9.47%). Referral rates as a proportion of CMHPs peak in 20-24 year olds (22.95%) and then decreases from this point until 74 years of age (6.00%). Attendance rates as a proportion of referrals peak in 60-64 year olds (79.97%) with lowest attendance rates in 20-24 year olds (57.34%). For those with two or more treatment sessions, there is a peak in MCID in 65 – 69 year olds (46.17%) with lowest improvement rates in 20-24 year olds (37.08%). Further detail can be found in table one.

The proportions of the population being referred, obtaining access, engaging with treatment and achieving MCID each peak in 25-29 year olds and decline thereafter, with lowest numbers for 70-74 year olds. Figure one shows the contrast graphically. Figure two depicts a *vertically magnified* version of Figure one showing the proportion of the population referred, obtaining access, continuing with treatment and achieving MCID from the total population.

Access uptake, continued treatment and achieving MCID, represented as a proportion of referrals is depicted in figure three. Of those referred: proportions of people obtaining access increases until 64 years (76.97%); proportions of people with 2+ treatment sessions increases until 59 years (35.31%); proportions of people achieving MCID increases until 69 years (15.86%).

The age group with the lowest proportion achieving MCID is 70-74 year olds (32.77%) but otherwise the percentage with MCID gradually increases from those aged 20-24 (37.08%) to those 65-69 years (46.17%), this age group having the highest proportion achieving MCID. This is depicted in Figure four.

In summary, more referrals are made for younger adults with a peak age of 25-29 years as a proportion of the total population and a peak age of 20-24 years as a proportion of those with CMHPs, but once referred, a higher proportions of older adults are engaging with and benefiting from treatment than 20-29 year olds.

DISCUSSION

Summary

Concerns about discrimination against older adults leading to reduced access to talking therapies have been widely shared[2, 3]. Our research has shown, taking estimated prevalence into account, that access is indeed lower for older adults and middle age compared to younger adults. The estimated prevalence of CMHPs peaks in 45-49 year olds but the proportions of those being referred peaks in 20-24 year olds. This is an important finding as it is possible that, given lower uptake, retention and improvement, there is over-referral of younger patients who either find it difficult to engage, or who are less likely to improve if they do engage or do not see the value of talking therapies at this point in their lives.

We have also shown that, once referred, older adults may benefit more from the IAPT service. Of those referred; the proportion of those obtaining access increases until 64 years, engaging with treatment increases until 59 years and achieving MCID increases until 69 years. Once referred, adherence to and recovery from treatment increases with increase in age and higher proportions of older adults are accessing and engaging with treatment than the 20-24 year olds who are being referred more frequently.

Comparison with existing literature

Patients can be signposted to the IAPT service by any appropriate referrer, and the main source of referrals is the GP. As such, GP decision making and practices regarding referral to psychological therapy services will have a large impact on access for patients. Cooper and colleagues[8] found younger adults (16-34 years) more likely than older adults (75+ years) with the same severity to have seen their GP regarding a mental health issue and to be receiving talking therapy treatment. A combination of factors may contribute to lower referral rates of older adults by health care professionals: self-stigma towards mental health in older adults leading to reduced disclosure and requests for help[11, 14, 15]; increased likelihood in receiving prescribed medication(s)[8]; professional attitudes[10]; multi-morbidity reducing recognition; and system factors which prevent access to those who are frail or homebound. It seems likely that reasons for the reduced referral we have shown are multi-factorial. However given the greatly higher contact rates between older adults and GPs than for younger adults, the reduced referral rates are even more striking. While there are good grounds for believing that GPs may not be offering the opportunity of referral to older adults, it is also likely that patients may believe they can 'manage themselves', making them less likely to disclose information to their GP, or accept suggested help[14, 15].

The estimated capacity of the patient to benefit from psychological therapy is a prominent feature included in a GP's referral decision[21] and they may also assume certain age groups will not engage with the service. Our study should demonstrate to GPs that older patients are both more likely to attend and more likely to benefit once engaged in treatment. GPs should perhaps therefore work to discuss mental health problems with older adults and increase awareness of the different available therapies, and their potential benefits. IAPT services may also need to take note. While those who were referred attended more reliably it is also possible that the nature of services are more suited to young people and that this is a disincentive to referral. These recommendations may also apply to those in mid-age. It is harder to draw conclusions about younger people and it is not clear as to whether, in some high referring PCTs, more numbers of young people are presenting with distress or access for younger people has achieved an optimum. It is also possible that if we can improve therapy engagement in these younger age groups they will be more likely to benefit from these types of treatments.

Limitations and Strengths

The data represent populations who have been referred to the IAPT service, and not those using other primary or secondary care services. It is important to note that the APMS only included

those living in private households, excluding those in care homes[22]. Nonetheless, the APMS series is the most recent and detailed data available for comparison of IAPT service use.

The data described above is purely quantitative and although we can speculate, it is difficult to explain why these differences in referral, engagement and outcome exist between patients from different age groups. Other studies have indicated some of the potential reasons in relation to service configuration but have not focussed on older adults[23].

Implications for practice

A number of factors are likely to affect access to IAPT services. Where possible, these need to be considered when evaluating the ability of new IAPT services to achieve their access targets. When considering age and specific age groups facing barriers to IAPT service use, the main inequity seems to be at the referral stage. Although 20-29 year olds are being referred in the largest numbers, the proportion remaining engaged with treatment increases with age. Barriers to engagement with the IAPT service in younger populations may be overcome by using different technologies, for example. Older adults are being under referred but benefit largely once obtaining access to the service. This suggests these inequities need to be acknowledged and addressed. Several barriers to treatment associated with age have been identified in recent work, including older patients' own perceptions, attitudes and behaviours towards mental health and associated talking treatments, and communication problems between the patient and doctor.

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Ethical approval

The dataset was created for a service evaluation project of the IAPT services commissioned by the South West Strategic Health Authority. Ethical approval was sought from and granted by the Cornwall and Plymouth Research Ethics Committee (Approval no. 09/H0203/91).

Declaration of interest

This work was conducted as part of the South West of England IAPT Evaluation Project, commissioned by the South West Strategic Health Authority, with additional contributions from the NIHRs PenCLAHRC. The views expressed in this paper are those of the authors and not

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Table 1: Detail of population and referrals in the South West across age including: total population; total number of referrals; referrals as a proportion of population; and estimated prevalence

Age	(years)	18-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
Population	(count)	253,936	293,070	260,578	299,820	354,084	361,746	324,621	307,731	345,264	285,479	243,231	214,057
Estimated CMHP cases	(count)	35,001	44,942	49,269	51,344	63,188	72,673	66,849	62,190	55,179	43,676	23,892	20,270
	(% of pop.)	13.78	15.33	18.91	17.12	17.85	20.09	20.59	20.21	15.98	15.30	9.82	9.47
Referrals	(count)	3,527	10,313	10,199	9,568	9,582	10,071	8,885	6,681	5,152	3,595	2,321	1,217
	(% of pop)	1.39	3.52	3.91	3.19	2.71	2.78	2.74	2.17	1.49	1.26	0.95	0.57
	(% of CMHP cases)	10.08	22.95	20.70	18.64	15.16	13.86	13.29	10.74	9.34	8.23	9.71	6.00
Attendees	(count)	2,033	5,913	6,205	6,155	6,438	6,916	6,400	4,868	3,954	2,767	1,774	905
	(% of pop)	0.80	2.02	2.38	2.05	1.82	1.91	1.97	1.58	1.15	0.97	0.73	0.42
	(% of CMHP cases)	5.81	13.16	12.59	11.99	10.19	9.52	9.57	7.83	7.17	6.34	7.43	4.46
	(% of referrals)	57.64	57.34	60.84	64.33	67.19	68.67	72.03	72.86	76.75	76.97	76.43	74.36
Completers (>=2 sessions)	(count)	675	2,384	2,492	2,486	2,716	2,949	2,723	2,139	1,819	1,266	797	412
	(% of pop)	0.27	0.81	0.96	0.83	0.77	0.82	0.84	0.70	0.53	0.44	0.33	0.19
	(% of CMHP cases)	1.93	5.30	5.06	4.84	4.30	4.06	4.07	3.44	3.30	2.90	3.34	2.03
	(% of referrals)	19.14	23.12	24.43	25.98	28.34	29.28	30.65	32.02	35.31	35.22	34.34	33.85
	(% of attendees)	33.20	40.32	40.16	40.39	42.19	42.64	42.55	43.94	46.00	45.75	44.93	45.52
Reliable improvement	(count)	263	884	983	994	1,121	1,269	1,143	906	789	560	368	135
	(% of pop)	0.10	0.30	0.38	0.33	0.32	0.35	0.35	0.29	0.23	0.20	0.15	0.06
	(% of CMHP cases)	0.75	1.97	2.00	1.94	1.77	1.75	1.71	1.46	1.43	1.28	1.54	0.67
	(% of referrals)	7.46	8.57	9.64	10.39	11.70	12.60	12.86	13.56	15.31	15.58	15.86	11.09
	(% of attendees)	12.94	14.95	15.84	16.15	17.41	18.35	17.86	18.61	19.95	20.24	20.74	14.92
	(% of completers)	38.96	37.08	39.45	39.98	41.27	43.03	41.98	42.36	43.38	44.23	46.17	32.77

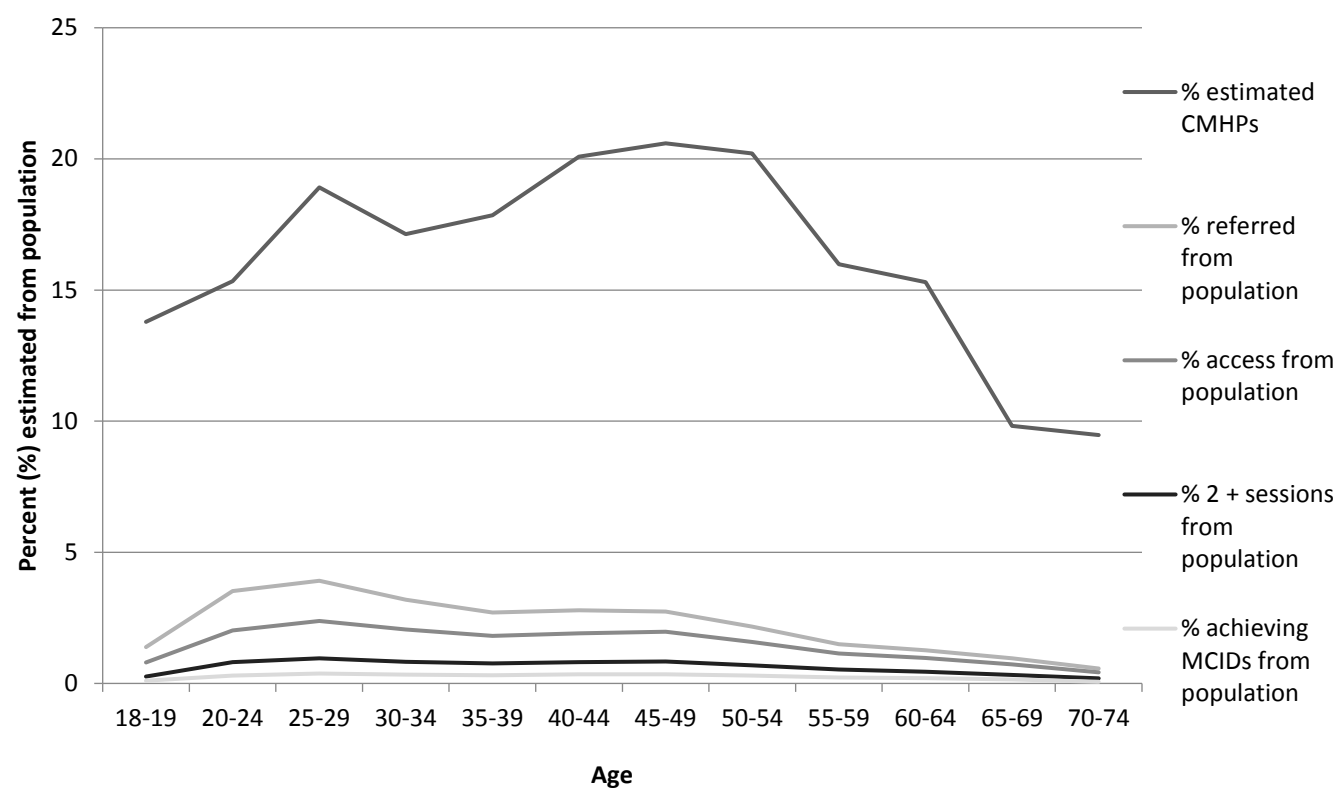


Figure 1: Estimated percent of CMHPs and number of those: referred, with access, with 2+ sessions, achieving MCID as a proportion of total population across age in the South West

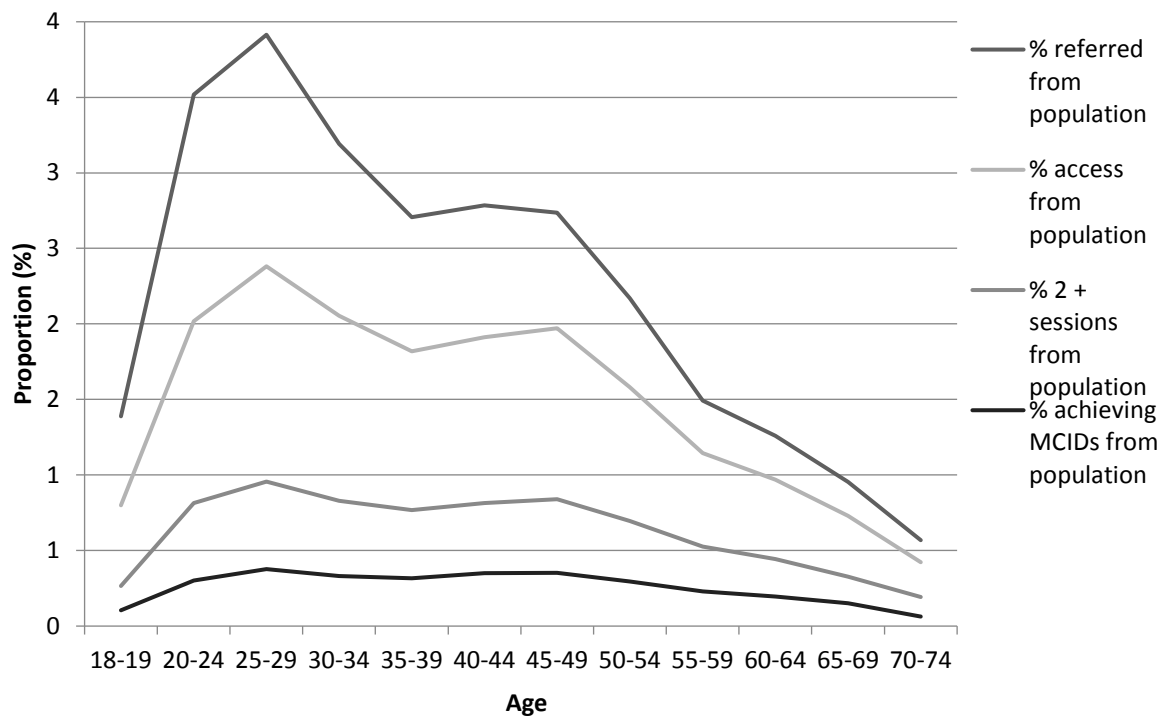


Figure 2: Number of those: referred, with access, with 2+ sessions, achieving MCID as a proportion of total population across age in the South West

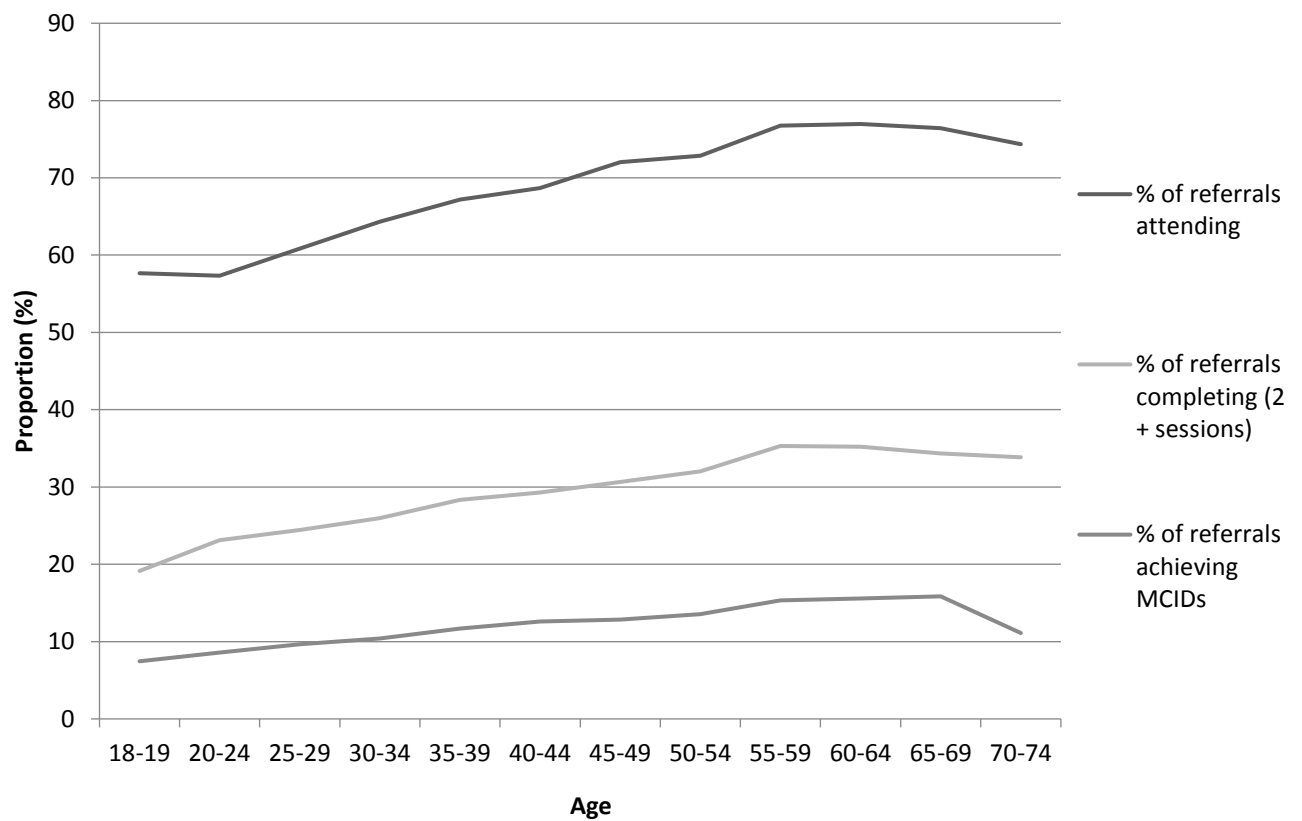


Figure 3: Number of those: with access, with 2+ sessions, achieving MCID as a proportion of those referred across age in the South West

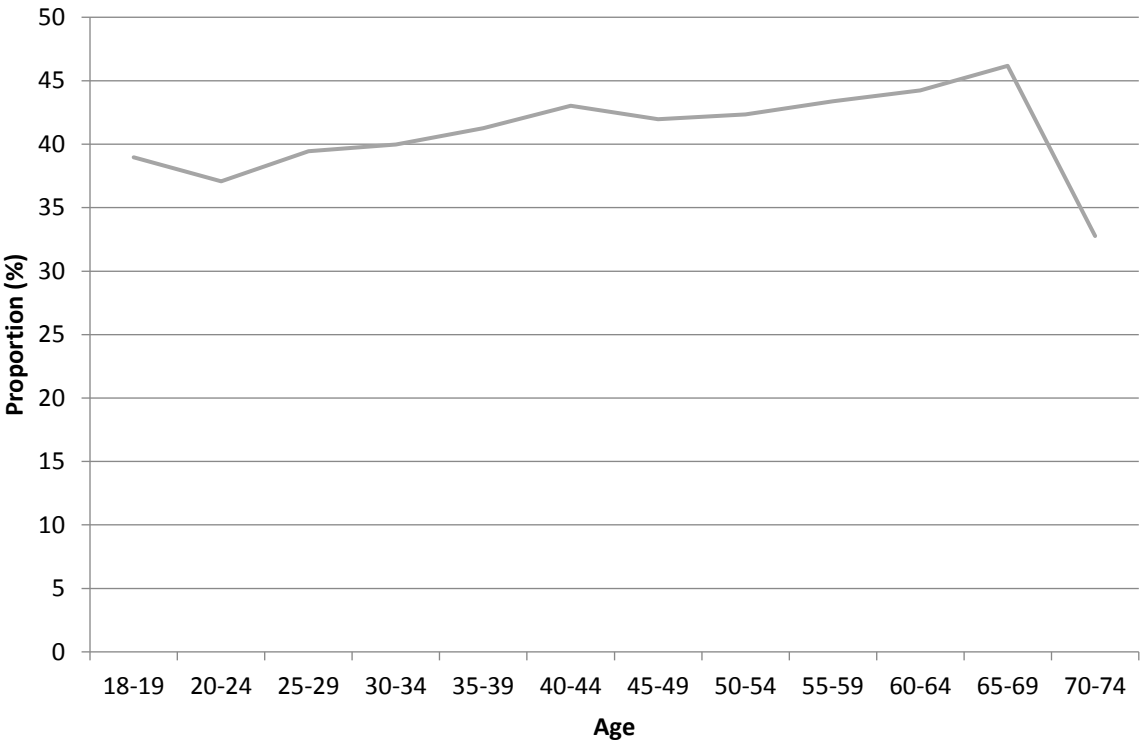


Figure 4: Those achieving MCID as a proportion of those with 2+ treatment sessions across age in the South West